General

Guideline Title

Emergency contraception.

Bibliographic Source(s)

Clinical Effectiveness Unit. Emergency contraception. London (UK): Faculty of Sexual and Reproductive Healthcare (FSRH); 2017 Dec. 52 p. [116 references]

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Clinical Effectiveness Unit. Emergency contraception. London (UK): Faculty of Sexual and Reproductive Healthcare (FSRH); 2012 Jan. 21 p. [71 references]

This guideline meets NGC's 2013 (revised) inclusion criteria.

NEATS Assessment

National Guideline Clearinghouse (NGC) has assessed this guideline's adherence to standards of trustworthiness, derived from the Institute of Medicine's report Clinical Practice Guidelines We Can Trust.

= Poor = Fair = Good = Very Good = Excellent

Assessment	Standard of Trustworthiness
YES	Disclosure of Guideline Funding Source
	Disclosure and Management of Financial Conflict of Interests
	Guideline Development Group Composition
YES	Multidisciplinary Group

YES	Methodologist Involvement
▮▮▮▮▯	Patient and Public Perspectives
	Use of a Systematic Review of Evidence
▮▮▮▮▮	Search Strategy
▮▮▮▮▯	Study Selection
▮▮▮▮▮	Synthesis of Evidence
	Evidence Foundations for and Rating Strength of Recommendations
▮▮▮▮▯	Grading the Quality or Strength of Evidence
▮▮▮▮▯	Benefits and Harms of Recommendations
▮▮▮▮▮	Evidence Summary Supporting Recommendations
▮▮▮▮▯	Rating the Strength of Recommendations
▮▮▮▮▮	Specific and Unambiguous Articulation of Recommendations
▮▮▮▮▮	External Review
▮▮▮▮▮	Updating

Recommendations

Major Recommendations

The recommendation grades (A-C, Good Practice Point [GPP]) are defined at the end of the "Major Recommendations" field.

When Is Emergency Contraception (EC) Indicated?

Women who do not wish to conceive should be offered EC after unprotected sexual intercourse (UPSI) that has taken place on any day of a natural menstrual cycle. (Grade D)

Women who do not wish to conceive should be offered EC after:

- UPSI from Day 21 after childbirth (unless the criteria for lactational amenorrhoea are met). (GPP)
- UPSI from Day 5 after abortion, miscarriage, ectopic pregnancy or uterine evacuation for gestational trophoblastic disease (GTD). (GPP)

Women who do not wish to conceive should be offered EC after UPSI if their regular contraception has been compromised or has been used incorrectly. (GPP)

Provision of EC

What Are the Responsibilities of EC Providers?

EC providers who cannot offer all EC methods should give women information regarding the other

methods and signpost them to services that can provide them. If a woman is referred on for a copper intrauterine device (Cu-IUD), oral EC should be given at the time of referral in case the Cu-IUD cannot be inserted or the woman changes her mind. (GPP)

Providers of oral EC should advise women that oral EC methods do not provide contraceptive cover for subsequent UPSI and that they will need to use contraception or abstain from sex to avoid further risk of pregnancy. (GPP)

Women requesting EC should be given information regarding all methods of ongoing contraception and how to access these. (GPP)

How Effective Are the Different Methods of EC?

EC providers should advise women that the Cu-IUD is the most effective method of EC. (Grade C)

EC providers should advise women that ulipristal acetate EC (UPA-EC) has been demonstrated to be effective for EC up to 120 hours after UPSI. (Grade B)

EC providers should advise women that levonorgestrel EC (LNG-EC) is licensed for EC up to 72 hours after UPSI. The evidence suggests that LNG-EC is ineffective if taken more than 96 hours after UPSI. (Grade B)

EC providers should advise women that UPA-EC has been demonstrated to be more effective than LNG-EC. (Grade B)

EC providers should advise women that the available evidence suggests that oral EC administered after ovulation is ineffective. (Grade B)

What Is the Effect of Weight/Body Mass Index (BMI) on the Effectiveness of EC?

Women should be informed that the effectiveness of the Cu-IUD is not known to be affected by weight or BMI. (GPP)

Women should be informed that it is possible that higher weight or BMI could reduce the effectiveness of oral EC, particularly LNG-EC. (Grade C)

What Drug Interactions Are Relevant to Use of EC?

EC providers should advise women using enzyme-inducing drugs that the effectiveness of UPA-EC and LNG-EC could be reduced. (Grade D)

Women requiring EC who are using enzyme-inducing drugs should be offered a Cu-IUD if appropriate. A 3 mg dose of LNG can be considered but women should be informed that the effectiveness of this regimen is unknown. A double-dose of UPA-EC is not recommended. (GPP)

EC providers should be aware that the effectiveness of UPA-EC could be reduced if a woman takes progestogen in the 5 days after taking UPA-EC. (GPP)

EC providers should be aware that the effectiveness of UPA-EC could theoretically be reduced if a woman has taken progestogen in the 7 days prior to taking UPA-EC. (GPP)

Are There Any Contraindications/Restrictions to Use of EC?

EC providers should be aware that the contraindications to insertion of a Cu-IUD for EC are the same as those for routine IUD insertion. (Grade D)

EC providers should be aware that UPA-EC is not suitable for use by women who have severe asthma controlled by oral glucocorticoids. (Grade D)

Are There Any Specific Considerations for Women Who Are Breastfeeding and Require EC?

EC providers should be aware that breastfeeding women have a higher relative risk of uterine perforation during insertion of intrauterine contraception than non-breastfeeding women. However, the absolute risk of perforation is low. (Grade B)

Breastfeeding women should be advised not to breastfeed and to express and discard milk for a week after they have taken UPA-EC. (Grade D)

Women who breastfeed should be informed that available limited evidence indicates that LNG-EC has no adverse effects on breastfeeding or on their infants. (Grade C)

What Methods of EC Should Be Offered to a Woman Who Has Had UPSI and Wishes to Avoid Pregnancy? (See decision-making algorithms to facilitate choice of EC)

All women requiring EC should be offered a Cu-IUD if appropriate as it is the most effective method of EC. (GPP)
EC providers should be aware that a Cu-IUD can be inserted up to 5 days after the first UPSI in a natural menstrual cycle, or up to 5 days after the earliest likely date of ovulation (whichever is later). (GPP)
If a Cu-IUD is not appropriate or not acceptable, women should be advised that oral EC should be taken as soon as possible if there has been UPSI within the last 5 days. (GPP)
EC providers should consider UPA-EC as the first-line oral EC for a woman who has had UPSI 96–120 hours ago (even if she has also had UPSI within the last 96 hours). (GPP)
EC providers should consider UPA-EC as the first-line oral EC for a woman who has had UPSI within the last 5 days if the UPSI is likely to have taken place during the 5 days prior to the estimated day of ovulation. (GPP)
EC providers should advise women that the available evidence suggests that oral EC administered after ovulation is ineffective. (Grade B)
Adolescents who need EC should be offered all methods of EC including the Cu-IUD. (GPP)
Women requiring EC after sexual assault should be offered all methods of EC including the Cu-IUD. (GPP)

Can Oral EC Be Used if There Has Also Been UPSI Earlier in the Cycle?

EC providers can offer a woman UPA-EC or LNG-EC if she has had UPSI earlier in the same cycle as well as within the last 5 days, as evidence suggests that UPA-EC and LNG-EC do not disrupt an existing pregnancy and are not associated with fetal abnormality. (Grade D)

Can Oral EC Be Used More Than Once in a Cycle?

If a woman has already taken UPA-EC once or more in a cycle, EC providers can offer her UPA-EC again after further UPSI in the same cycle. (Grade D)
If a woman has already taken LNG-EC once or more in a cycle, EC providers can offer her LNG-EC again after further UPSI in the same cycle. (Grade D)
EC providers should be aware that if a woman has already taken UPA-EC, LNG-EC should not be taken in the following 5 days. (GPP)
EC providers should be aware that if a woman has already taken LNG-EC, UPA-EC could theoretically be less effective if taken in the following 7 days. (GPP)

What Should Women Be Advised Regarding Future Contraception?

EC providers should advise women that the Cu-IUD provides effective ongoing contraception. (GPP)
EC providers should advise women that oral EC methods do not provide ongoing contraception. (GPP)
EC providers should advise women that after oral EC there is a pregnancy risk if there is further UPSI and ovulation occurs later in the same cycle. (Grade B)
After taking LNG-EC, women should be advised to start suitable hormonal contraception immediately. Women should be made aware that they must use condoms reliably or abstain from sex until contraception becomes effective. (Grade D)
Women should be advised to wait 5 days after taking UPA-EC before starting suitable hormonal contraception. Women should be made aware that they must use condoms reliably or abstain from sex during the 5 days waiting and then until their contraceptive method is effective. (Grade D)
If a woman and her EC provider estimate that UPSI is unlikely to have occurred during her fertile period, she may consider the option of using LNG-EC with immediate start of hormonal contraception rather than UPA-EC with delayed start of hormonal contraception. (GPP)

Definitions

Grading of Recommendations

A: At least one systematic review, meta-analysis or randomised controlled trial (RCT) rated as 1++, and directly applicable to the target population; *or* a systematic review of RCTs or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population and demonstrating overall consistency of results.

B: A body of evidence including studies rated as 2++ directly applicable to the target population and demonstrating overall consistency of results; *or* extrapolated evidence from studies rated as 1++ or 1+.

C: A body of evidence including studies rated as 2+ directly applicable to the target population and demonstrating overall consistency of results; *or* extrapolated evidence from studies rated as 2++.

D: Evidence level 3 or 4; *or* extrapolated evidence from studies rated as 2+.

Good Practice Point: Good Practice Points based on the clinical experience of the guideline development group.*

*On the occasion when the GDG finds there is an important practical point that they wish to emphasise but for which there is not, nor is there likely to be, any research evidence. This will typically be where some aspect of treatment is regarded as such sound clinical practice that nobody is likely to question it. It must be emphasised that these are NOT an alternative to evidence-based recommendations, and should only be used where there is no alternative means of highlighting the issue.

Clinical Algorithm(s)

The following clinical algorithms are provided in the original guideline document:

Algorithm 1: Decision-making Algorithm for Emergency Contraception (EC): Copper Intrauterine Device (Cu-IUD) vs. Oral EC
Algorithm 2: Decision-making Algorithm for Oral Emergency Contraception (EC): Levonorgestrel EC (LNG-EC) vs. Ulipristal Acetate EC (UPA-EC)

Scope

Disease/Condition(s)

Unintended pregnancy

Guideline Category

Counseling

Evaluation

Management

Prevention

Clinical Specialty

Family Practice

Internal Medicine

Obstetrics and Gynecology

Preventive Medicine

Intended Users

Advanced Practice Nurses

Health Care Providers

Nurses

Pharmacists

Physician Assistants

Physicians

Public Health Departments

Guideline Objective(s)

- To update previous Faculty of Sexual & Reproductive Healthcare (FSRH) guidance
- To summarise the available evidence on emergency contraception (EC)
- To recommend safe and appropriate clinical practice in relation to the provision of different contraceptive methods

Target Population

Women who do not wish to conceive and who have had unprotected sexual intercourse (UPSI)

Interventions and Practices Considered

1. Advising patients regarding emergency contraception, including effectiveness of different methods and relevant drug interactions
2. Use of emergency contraception, as indicated
    - Copper-bearing IUD (Cu-IUD)
    - Levonorgestrel (LNG)
    - Ulipristal acetate (UPA)
3. Consideration of potential drug interactions
4. Consideration of specific populations, including patients who are breastfeeding, those who are overweight or have high body mass index (BMI), adolescents, and patients at risk of pregnancy after sexual assault
5. Provision of information regarding ongoing contraception methods and how to access them

Major Outcomes Considered

- Rate of unintended pregnancy/emergency contraception failure rates
- Rate of initiation and continuation of ongoing contraception
- Acceptability
- Adverse events (e.g., drug interactions, side effects, ectopic pregnancy, adverse pregnancy outcomes, fetal abnormality)
- Accuracy of estimated ovulation
- Lifespan of sperm in the genital tract
- Ovulation in 5 days
- Risk of pregnancy
- Pregnancy/ovulation/ovulation markers
- Sexual risk-taking behaviours and behavioural changes (rates of unprotected sexual intercourse

[UPSI], number of partners, contraceptive use)

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Systematic Review of Evidence

A systematic review of the literature was conducted to identify evidence to answer the clinical questions formulated and agreed by the guideline development group (GDG). Searches were performed using relevant medical subject headings and free-text terms using the following databases: PubMed, EMBASE, Cochrane Central Register of Controlled Trials, Cochrane Database of Systematic Reviews, the Cumulative Index to Nursing and Allied Health Literature (CINAHL) and POPLINE®. Further, the National Guideline Clearinghouse (NGC) and Scottish Intercollegiate Guideline Network (SIGN) were also used to identify relevant guidelines produced by other organisations; these guidelines were checked to identify missing evidence. No language restrictions were applied to the searches.

Search Date

The databases were initially searched up to 21 October 2016. The evidence identified up to this point was used to develop the first draft of the guideline. Any evidence published after this date was not considered for inclusion.

Search Strategy

The literature search was performed separately for the different sub-categories covered in this clinical guideline. The search terms used are listed in Appendix 1 of the original guideline document.

Articles identified from the search were screened by title and abstract and full-text copies were obtained if the articles addressed the clinical questions relevant to the guideline. A full critical appraisal of each article was conducted. Studies that did not report relevant outcomes or were not relevant to the clinical questions were excluded.

Number of Source Documents

Studies included:

Populations, Intervention, Comparator, and Outcome (PICO) 1: 6
PICO 2: 3
PICO 3: 6
PICO 4a: 50
PICO 4b: 15
PICO 5: 12
PICO 6: 1
PICO 7: 0
PICO 8: 30
PICO 9: 5
PICO 10: 3

PICO 11: 6
PICO 12a: 7
PICO 12b: 2
PICO 13: 13
PICO 14: 7
PICO 15: 3
PICO 16: 3
PICO 17: 15

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Classification of Evidence Levels

1++: High-quality systematic reviews or meta-analysis of randomised controlled trials (RCTs) or RCTs with a very low risk of bias.

1+: Well-conducted systematic reviews or meta-analysis of RCTs or RCTs with a low risk of bias.

1-: Systematic reviews or meta-analysis of RCTs or RCTs with a high risk of bias.

2++: High-quality systematic reviews of case-control or cohort studies or high-quality case-control or cohort studies with a very low risk of confounding, bias or chance and a high probability that the relationship is causal.

2+: Well-conducted case-control or cohort studies with a low risk of confounding, bias or chance and a moderate probability that the relationship is causal.

2-: Case-control or cohort studies with a high risk of confounding, bias or chance and a significant risk that the relationship is not causal.

3: Non-analytical studies (e.g. case report, case series).

4: Expert opinions.

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

The recommendations are graded (A, B, C, D and Good Practice Point) according to the level of evidence upon which they are based. The highest level of evidence that may be available depends on the type of clinical question asked. The Clinical Effectiveness Unit (CEU) adopts the comprehensive methodology developed by the Grading of Recommendations Assessment, Development and Evaluation (GRADE) (http://www.gradeworkinggroup.org/) to assess the strength of the evidence collated and for generating recommendations from evidence.

Methods Used to Formulate the Recommendations

Description of Methods Used to Formulate the Recommendations

Who Has Developed the Guideline?

Development of the guideline was led by the secretariat (Clinical Effectiveness Unit [CEU] staff) and involved the intended users of the guidelines (contraception providers) and patient/service user representatives as part of a multidisciplinary group. The scope of the guideline was informed by a scoping survey conducted amongst members of the Faculty of Sexual and Reproductive Healthcare (FSRH) and amongst service users from three sexual and reproductive health services across the United Kingdom (UK) (Sandyford [Glasgow], Scotland; Brook [Liverpool & Wirral and Milton Keynes], England; Aneurin Bevan University Health Board [Gwent], Wales). The first draft of the guideline was produced based on the final scope of the guideline agreed by the guideline development group (GDG). The first draft of the guideline (version 0.1) was reviewed by the GDG and discussed at a face-to-face meeting held at the CEU (Edinburgh, Scotland) on 24 May 2016. A revised draft guideline (version 0.2) was produced in response to comments received at the meeting.

Guideline Development Methodology

This FSRH guideline was developed in accordance with the standard methodology for developing FSRH clinical guidelines (outlined in the FSRH's *Framework for Clinical Guideline Development* [see the "Availability of Companion Documents" field). The methodology used in the development of this guideline has been accredited by the National Institute for Health and Care Excellence (NICE).

Considerations When Making Recommendations

FSRH clinical guidelines are produced primarily to recommend safe and appropriate clinical practice in relation to the provision of different contraceptive methods. Therefore, when formulating the recommendations, the GDG takes into consideration the health benefits, side effects and other risk associated with implementing the recommendations, based on the available evidence and expert opinion. Further, the GDG takes into consideration the different financial and organisational barriers that clinicians and services may face in the implementation of recommendations to ensure that the recommendations are realistic and achievable.

Reaching Consensus on the Recommendations

When further revisions based on public consultation feedback have been made, members of the GDG were asked to complete a form to indicate whether they agree or disagree with the recommendations proposed. The consensus process is as follows:

> Consensus will be reached when 80% of the GDG members agree with the recommendation.
> Recommendations where consensus is not reached will be redrafted in the light of any feedback.
> The recommendation consensus form will be sent again for all recommendations. Consensus will be reached when 80% of the GDG members agree with the recommendation.
> If consensus is not reached on certain recommendations, these will be redrafted once more.
> If after one more round of consultation, consensus is still not reached, the recommendation will be taken to the CEC for final decision.
> Any group member who is not content with the decision can choose to have their disagreement noted within the guideline.

Rating Scheme for the Strength of the Recommendations

Grading of Recommendations

A: At least one systematic review, meta-analysis or RCT rated as 1++, and directly applicable to the

target population; *or* a systematic review of RCTs or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population and demonstrating overall consistency of results.

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Good Practice Point: Good Practice Points based on the clinical experience of the guideline development group (GDG).*

*On the occasion when the GDG finds there is an important practical point that they wish to emphasise but for which there is not, nor is there likely to be, any research evidence. This will typically be where some aspect of treatment is regarded as such sound clinical practice that nobody is likely to question it. It must be emphasised that these are NOT an alternative to evidence-based recommendations, and should only be used where there is no alternative means of highlighting the issue.

Cost Analysis

The guideline developers reviewed published cost analyses. See Section 22 in the original guideline document for information on the comparative cost-effectiveness of different methods of emergency contraception (EC).

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

The draft guideline was revised again after further comments from the guideline development group (GDG), after which the draft guideline (version 0.3) was sent to international and United Kingdom (UK)-based external independent reviewers suggested by the GDG at the face-to-face meeting. A further revision to the draft guideline was made to produce draft guideline (version 0.4) which was put on the Faculty of Sexual and Reproductive Healthcare (FSRH) Web site for public consultation between 9 November and 7 December 2016. The revised draft guideline (version 0.5) was sent to the GDG for final comments and to reach consensus on the recommendations (details of this process given later). Service users were consulted at both the scoping stage and during the late drafting stages to ensure that their input was considered throughout the process.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

- A copper-bearing IUD (Cu-IUD) inserted for emergency contraception (EC) is immediately effective for ongoing contraception. The Cu-IUD offers reliable contraception for its licensed duration.
- The bulk of the available evidence suggests that increased accessibility of oral EC does not increase the frequency of unprotected sexual intercourse (UPSI), the likelihood of sexual risk-taking or the risk of sexually transmitted infection (STI) and does not make women less likely to use effective contraception.

Potential Harms

- Clinicians should be aware that there is an increased relative risk of perforation at the time of insertion of intrauterine contraception in the postpartum period and during breastfeeding.
- Ulipristal acetate (UPA) is excreted in breast milk. The safety of use of UPA emergency contraception (EC) during breastfeeding has not been studied. The summary of product characteristics (SPC) for ellaOne advises that breastfeeding is avoided for a week after using UPA-EC; milk should be expressed and discarded during that time.
- Metabolism of both UPA-EC and levonorgestrel EC (LNG-EC) is increased by liver enzyme-inducing drugs. This may reduce their effectiveness as EC.
- Oral EC, particularly LNG-EC, could be less effective if a woman has a higher body weight or body mass index (BMI).
- Systematic review of safety data for adverse events relating to use of EC by healthy women concludes that such events are rare. However, evidence for UPA-EC is limited. Headache, nausea and dysmenorrhoea are side effects common to both UPA-EC and LNG-EC and have been reported in around 10% of users.
- After UPA-EC, a small number of women had menses more than 7 days early and about 20% more than 7 days late. The delay was >20 days in 4% of women. Fewer than 10% of women reported intermenstrual bleeding. After LNG-EC, menstruation is delayed for over 7 days in fewer than 10% of women.
- Oral EC provides no ongoing contraception and the risk of pregnancy after oral EC is significantly greater amongst women who have further UPSI in the same cycle than amongst those who do not.
- Refer to Faculty of Sexual and Reproductive Healthcare (FSRH) Drug Interactions with Hormonal Contraception, available from the FSRH Web site .

Contraindications

Contraindications

- After gestational trophoblastic disease (GTD), if human chorionic gonadotrophin (hCG) levels are persistently elevated, insertion of a copper intrauterine device (Cu-IUD) is contraindicated (UK Medical Eligibility Criteria [UKMEC] 4) because of the theoretical risk of perforation and bleeding. IUD insertion is relatively contraindicated (UKMEC 3) while hCG levels are still falling after GTD.
- Use of a Cu-IUD for emergency contraception (EC) carries the same contraindications as routine Cu-IUD insertion.
- Ulipristal acetate EC (UPA-EC) is not suitable for use by women who have severe asthma controlled by oral glucocorticoids.
- Insertion of a Cu-IUD is relatively contraindicated between 48 hours and 28 days after delivery because of the possible increased risk of uterine perforation and expulsion.
- It is currently recommended that the levonorgestrel-releasing intrauterine system (LNG-IUS) should not be inserted unless pregnancy can be reasonably excluded.

Refer to Section 11 in the original guideline document for additional information on contraindications and

restrictions of EC use.

Qualifying Statements

Qualifying Statements

- The recommendations included should be used to guide clinical practice but are not intended to serve alone as a standard of medical care or to replace clinical judgement in the management of individual cases.
- Emergency contraception (EC) is intended for occasional use, to reduce the risk of pregnancy after unprotected sexual intercourse (UPSI). It does not replace effective regular contraception.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Audit Criteria/Indicators

Patient Resources

Staff Training/Competency Material

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Timeliness

Identifying Information and Availability

Bibliographic Source(s)

Clinical Effectiveness Unit. Emergency contraception. London (UK): Faculty of Sexual and Reproductive Healthcare (FSRH); 2017 Dec. 52 p. [116 references]

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2017 Dec

Guideline Developer(s)

Faculty of Sexual and Reproductive Healthcare - Professional Association

Source(s) of Funding

The Faculty of Sexual and Reproductive Healthcare (FSRH) is a registered charitable organisation which funds the development of its own clinical guidelines. National Health Service (NHS) Lothian is contracted to host the Clinical Effectiveness Unit (CEU) in the Chalmers Centre and to provide the CEU's services using ring-fenced funding from the FSRH. No other external funding is received. Chalmers Centre supports the CEU in terms of accommodation, facilities, education, training and clinical advice for the members' enquiry service. As an organisation, NHS Lothian has no editorial influence over CEU guidelines, although staff members may be invited to join the CEU's multidisciplinary guideline development groups (GDGs), in an individual professional capacity.

Guideline Committee

Clinical Effectiveness Unit

Composition of Group That Authored the Guideline

Guideline Development Group

Secretariat: Dr Ailsa Gebbie, Director, Clinical Effectiveness Unit; Dr Sarah Hardman, Deputy Director, Clinical Effectiveness Unit; Mrs Valerie Warner, Researcher, Clinical Effectiveness Unit

Multidisciplinary Group: Dr Aisling Baird, Consultant in Sexual and Reproductive Healthcare (Abacus Community Sexual Health Service, Liverpool); Ms Alison Craig, Nurse Consultant in Sexual and Reproductive Healthcare (Chalmers Centre, NHS Lothian); Dr Lynne Gilbert, Associate Specialist in Sexual and Reproductive Healthcare (iCASH Cambridgeshire) and Vice Chair Clinical Standards Committee, FSRH; Dr Jennifer Heathcote, Associate Specialist (East Cheshire Centre for Sexual Health, Macclesfield); Dr Diana Mansour, Consultant in Community Gynaecology and Reproductive Healthcare, Head of Clinical Service (Sexual Health, Newcastle), FSRH Vice-President Clinical Quality; Dr Anatole S Menon-Johansson, Clinical Lead for Sexual & Reproductive Health (Guy's & St Thomas' NHS Foundation Trust, London); Dr Lucy Michie, Specialty Trainee in Community Sexual and Reproductive Health (Sandyford Sexual Health Service, Glasgow); Dr Sarah Millar, Community Sexual and Reproductive Health Trainee (Chalmers Centre, NHS Lothian); Dr Priyanka Patel, Specialty Trainee in Community Sexual and Reproductive Health (Homerton Hospital); Mr Andrew Radley, Consultant in Public Health Pharmacy (Kings Cross Hospital, Dundee, NHS Tayside); Professor James Trussell, Senior Research Demographer (Princeton University),

Honorary Fellow (University of Edinburgh)

Financial Disclosures/Conflicts of Interest

Declaration of Interest

Dr Baird received an honorarium from HRA Pharma for a presentation at their symposium at Current Choices 2013 entitled "EC: Is choice achievable?". Dr Mansour has received financial support to attend pharmaceutical advisory board meetings, undertake research studies and speak at educational meetings and conferences along with travel grants from Aspen, Astellas, Bayer, Consilient Healthcare, HRA Pharma, Merck, Mithra, Pfizer and Vifor Pharma. Professor Gemzell-Danielsson serves on advisory boards and has been an invited speaker at scientific meetings for Bayer AG, MSD/Merck, HRA Pharma, Exelgyn, Actavis, NaturalCycles and Gedeon Richter on an ad hoc basis. Her institution has conducted studies sponsored by HRA Pharma, Mithra, Bayer and MSD/Merck. None of the individuals involved had competing interests that prevented their active participation in the development of this guideline.

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Clinical Effectiveness Unit. Emergency contraception. London (UK): Faculty of Sexual and Reproductive Healthcare (FSRH); 2012 Jan. 21 p. [71 references]

This guideline meets NGC's 2013 (revised) inclusion criteria.

Guideline Availability

Available from the Faculty of Sexual and Reproductive Healthcare Web site .

Availability of Companion Documents

The following is available:

> Clinical Effectiveness Unit. Framework for developing clinical guidelines. London (UK): Faculty of Sexual and Reproductive Healthcare (FSRH); 2016 Oct. 15 p. Available from the Faculty of Sexual and Reproductive Healthcare (FSRH) Web site .

Questions for continuing professional development and auditable outcomes are available in the original guideline document .

Patient Resources

Information for women requesting emergency contraception is available in the original guideline document .

NGC Status

This NGC summary was completed by ECRI on July 5, 2005. This summary was updated by ECRI Institute on May 15, 2008. This NGC summary was updated by ECRI Institute on December 6, 2011. This NGC summary was updated by ECRI Institute on March 7, 2012. This NGC summary was updated by ECRI Institute on December 4, 2017. The guideline developer agreed to not review the content.

This NEATS assessment was completed by ECRI Institute on October 31, 2017. The guideline developer

agreed to not review the content.

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